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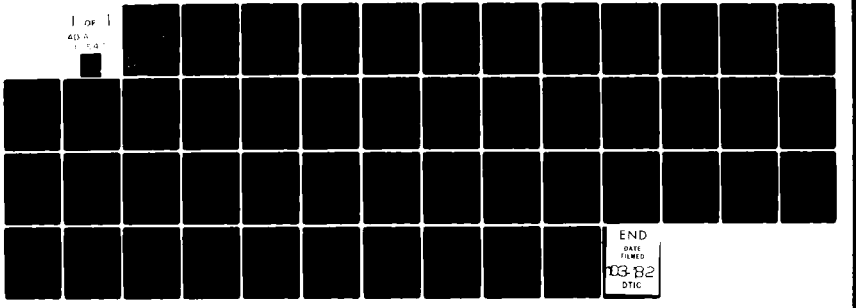

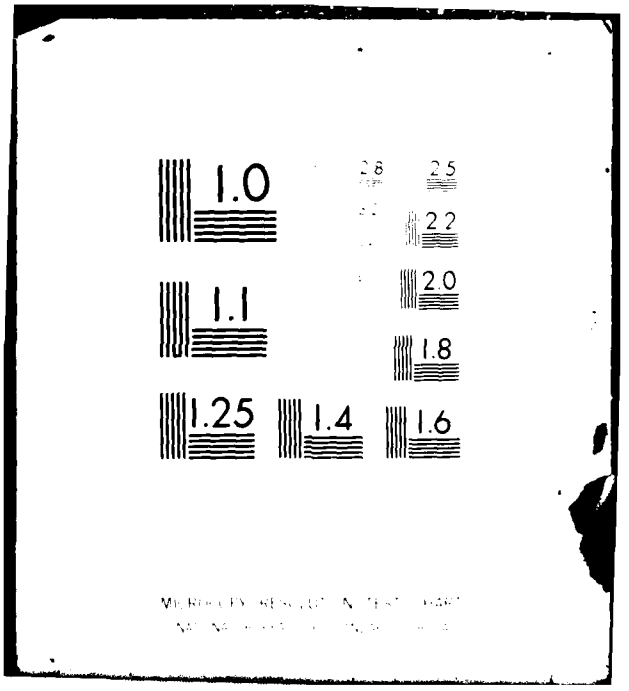
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BY THE U.S. GENERAL ACCOUNTING OFFICE

Report To The Honorable Pete V. Domenici United States Senate

Improved Knowledge Base Would Be Helpful In Reaching Policy Decisions On Providing Long-Term, In-Home Services For The Elderly

Long-term, in-home care consists of services to the elderly who, because of chronic functional disabilities, need assistance with basic activities of daily living.

Although it is known that some of the elderly have unmet needs for long-term, in-home care, it is also known that a large percentage of the cost of the care received is provided by family and friends.

Four Federal programs provide some type of long-term, in-home services. Each program has restrictions limiting the availability of services. Little is known about the ramifications of removing these restrictions.

In addition, studies have not provided conclusive evidence on how well long-term, in-home care would prevent or delay institutionalization of the elderly.

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HRD-82-4
OCTOBER 26, 1981

UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

HUMAN RESOURCES
DIVISION

B-201763

The Honorable Pete V. Domenici
United States Senate

Dear Senator Domenici:

In accordance with your request, we reviewed the provision of in-home health or health-related services under four Federal programs to determine how well the services meet the elderly's need for long-term, in-home care.

We are not making recommendations on the matters discussed in this report because we believe that more information would be helpful in making policy decisions concerning the needs of the elderly for long-term, in-home services. With more information, the costs and benefits which would flow from greater Federal support for in-home care could be better determined.

At the request of your office, we did not ask for agency comments concerning the matters discussed in this report. Also, based on your request we will make a public distribution of this report 30 days after the date of this letter. At that time, we will send copies of this report to the Honorable Bob Packwood; the Senate Special Committee on Aging; the House Select Committee on Aging; the Director, Office of Management and Budget; and the Secretary of Health and Human Services.

Sincerely yours,

Gregory J. Ahart
Director

GENERAL ACCOUNTING OFFICE
REPORT TO THE
HONORABLE PETE V. DOMENICI
UNITED STATES SENATE

IMPROVED KNOWLEDGE BASE WOULD BE HELPFUL IN REACHING POLICY DECISIONS ON PROVIDING LONG-TERM, IN-HOME SERVICES FOR THE ELDERLY

D I G E S T

The number of elderly persons in the United States--those 65 or older--is large and is rapidly increasing. The Nation's elderly population increased from about 9 million in 1940 to about 24 million in 1978 and is projected to reach 45 million by the year 2020. (See p. 1 .)

WHY THE REVIEW WAS MADE

On May 16, 1980, Senator Pete V. Domemici asked GAO to review the delivery of in-home services to the elderly under titles XVIII, XIX, and XX of the Social Security Act and title III of the Older Americans Act. Each of these programs, administered by the Department of Health and Human Services (HHS), presents different requirements on the availability and use of in-home services. However, all of the programs authorize services directed toward the goal of helping elderly persons by providing them with in-home assistance. In-home services could result in benefits, such as prolonged life, increased independence and/or reduced institutionalization for these elderly.

Long-term, in-home care consists of services to the elderly who, because of chronic functional disabilities, need assistance with basic activities of daily living. Most common is the need for homemaker/chore services, such as housecleaning or shopping assistance for elderly persons with heart problems. Many elderly also need assistance with such personal care services as bathing and dressing. (See p. 8.)

GAO studies, although not projectable to the total elderly population, have indicated that between 10 and 22 percent of the elderly 65 years of age and older were not receiving all the homemaker/chore and personal care services they need. In addition, GAO noted that, for the elderly who have their needs met, 76 percent of

the cost of these services is provided by the family and friends. (See p. 8.)

The Federal Government plays a role in the delivery of in-home services to the elderly. Four major Federal programs include in-home services among the services they provide. (See p. 12.)

The four Federal programs--Medicare (title XVIII), Medicaid (title XIX), and title XX of the Social Security Act, and title III of the Older Americans Act--offer personal care and homemaker/chore services in the home, even though in-home services are not their primary mandate. Each program has restrictions which limit the availability of such long-term, in-home assistance. Funding ceilings, for example, restrict the number of elderly who can receive long-term, in-home services under titles XX and III. Eligibility requirements restrict services available under Medicare and Medicaid. (See pp. 12 and 13.)

Liberalizing the in-home services eligibility requirements of Medicare and/or Medicaid would make in-home services available to more elderly persons which, in turn, would increase the cost of these programs. (See pp. 17 and 18.)

Various studies generally agree that in-home services prolong life and maintain or increase the elderly's independence. They disagree, however, on whether providing long-term, in-home assistance affects the number of elderly who are or would be receiving long-term care in nursing homes. (See p. 19.)

GAO noted that the National Commission on Social Security, in its report dated March 1981, recommends that a separate title of the Social Security Act be created to provide services other than acute medical and hospital care to needy persons who require long-term care. (See p. 22.)

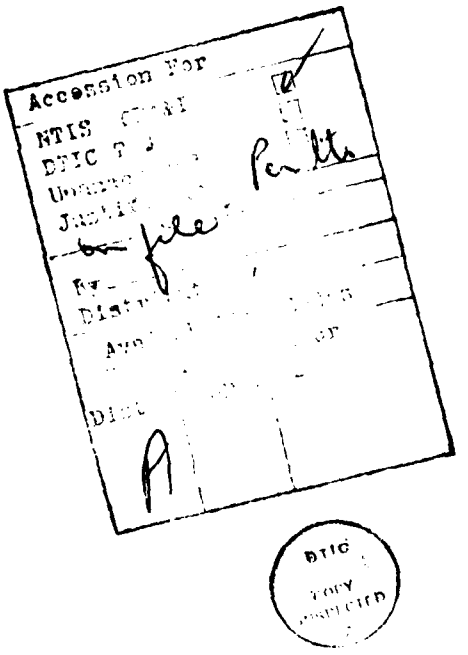
GAO believes more information would be helpful in the following areas in making policy decisions:

--What is the extent of the existing network of service providers (Federal, State, and local programs, family and friends, and voluntary sector) that are serving the elderly and why

approximately 10 to 22 percent of the elderly are not receiving services from this network.

--What is the cost of providing long-term, in-home services to the elderly and what effects a Federal subsidy of such services would have on the existing network that is serving the elderly. (See p. 25.)

At the request of Senator Pete V. Domenici's office, GAO did not obtain comments from HHS on the matters discussed in this report. It did discuss the report with HHS officials working in the long-term care for the elderly area, who agreed with GAO's conclusions that an improved knowledge base would be helpful in making policy decisions concerning in-home care for the elderly.



Contents

ABBREVIATIONS

DHS	Department of Human Services
GAO	General Accounting Office
HHS	Department of Health and Human Services
HCFA	Health Care Financing Administration
NTMC	Nontechnical medical care program
SSI	Supplemental Security Income

CHAPTER 1

INTRODUCTION

In a May 16, 1980, letter, Senator Pete V. Domenici asked us to review the delivery of in-home health or health-related services to the elderly under titles XVIII, XIX, and XX of the Social Security Act and title III of the Older Americans Act. Each of these programs, administered by the Department of Health and Human Services (HHS), presents different requirements on the availability and use of in-home type services. However, all of the programs authorize services directed toward the goal of helping elderly persons by providing them with in-home assistance.

THE ELDERLY CONSTITUTE A LARGE SEGMENT OF THE POPULATION

The number of elderly 1/ persons in the United States is large and is rapidly increasing. The Nation's elderly population increased from about 9 million in 1940 to about 24 million in 1978 and is projected to reach 45 million by the year 2020. The elderly also represent an increasing percentage of the Nation's population. For instance, in 1940 the elderly represented about 7 percent of the population. By 1978, their representation had increased to about 11 percent. Also increasing is the percentage of the elderly who are over age 75. The Commissioner on Aging, in the annual report for fiscal year 1979, stated that about 40 percent of the elderly population was over age 75 and that this percentage was expected to increase to 45 by the year 2020.

Many elderly persons have some degree of functional disability--a physical or health condition that limits an individual's ability to perform self-maintenance activities essential to daily living. In a 1977 study, the National Center for Health Statistics estimated the following percentages of the noninstitutionalized elderly who had some degree of functional disability.

Age group	Percent of age group with some degree of functional disability
65 to 74	39
75 to 84	50
85 and older	63

1/As used in this report "elderly" refers to persons age 65 and older.

FOUR FEDERAL PROGRAMS FUND IN-HOME SERVICES FOR THE ELDERLY

The Federal Government plays a significant role in the delivery of in-home health or health-related services to the elderly through four major programs. The basic characteristics of each are presented below.

Medicare

Medicare, authorized by title XVIII of the Social Security Act (42 U.S.C. 1395), provides a broad health insurance program for most persons age 65 and over. Medicare offers two types of insurance protection for the aged and disabled--hospital insurance (part A) and supplemental medical insurance (part B). Both types of insurance provide home health care to eligible beneficiaries.

The Medicare program--administered by HHS' Health Care Financing Administration (HCFA)--is a federally financed program with Federal standards and reimbursement principles. Reimbursement of home health agencies for services is handled through fiscal intermediaries under contract to the Federal Government.

Home health services as defined by the Social Security Act include

--part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse;

--physical, occupational or speech therapy;

--medical social services under the direction of a physician;

--part-time or intermittent services of a home health aid as permitted by regulations;

--medical supplies (other than drugs and medication, including serum and vaccinations) and the use of medical appliances; and

--medical services provided by an intern or resident enrolled in a teaching program in hospitals affiliated or under contract with a home health agency.

Regional representatives of HCFA monitor the activities of the fiscal intermediaries.

Medicare paid about $28 billion in benefits during calendar year 1979. About $0.6 billion (2.1 percent) of that amount was reimbursed for home health care. The other expenditures were for other services for which Medicare beneficiaries were eligible (i.e., hospitals, skilled nursing facilities, physician services, etc.).

Medicaid

Medicaid, authorized by title XIX of the Social Security Act (42 U.S.C. 1396), provides health services to low-income persons. Persons receiving cash assistance under title IV (Aid to Families with Dependent Children) or title XVI (Supplemental Security Income) of the Social Security Act are automatically eligible for Medicaid services. States may also serve persons who are not receiving cash assistance, but whose income and resources are insufficient to meet the costs of medical services.

The Medicaid program authorized two types of in-home services: home health services and personal care services. Home health services include skilled and unskilled services, both of which must be provided by home health agencies certified to provide such services under the Medicare program. Personal care services consist only of unskilled services, and they do not have to be provided by a Medicare-certified home health agency. Providing home health services is mandatory; for example, they must be included in the State Plan. But providing personal care services is optional.

Although federally subsidized, Medicaid is administered by the States. As a minimum, the Federal Government will pay 50 percent of the costs incurred by a State in providing health care under Medicaid. In low per capita income States, the Federal share can increase to 78 percent. The States are responsible for enforcing the Federal standards and monitoring the operations of provider agencies. Provider agencies are reimbursed directly by the States or by fiscal agents which are under contract to the States. At the Federal level, HCFA administers the Medicaid program, and it is responsible for evaluating States' Medicaid programs.

Federal and State Medicaid expenditures were about $18 billion in fiscal year 1978. 1/ Of this amount, expenditures for home health services were about $211 million (1.2 percent). The remaining expenditures were for other services provided to eligible persons (i.e., inpatient hospital services, nursing home care, etc.).

1/Latest year for which expenditure data were available.

Title XX

In 1975, the Congress amended the Social Security Act by adding a new provision, title XX (42 U.S.C. 1397), which authorized and delineates a comprehensive program of social services. 1/ States may offer one or more services to anyone who receives cash payments under the Aid to Families with Dependent Children or Supplemental Security Income (SSI) programs and to persons whose income does not exceed 115 percent of the State's median income adjusted for family size.

Federal expenditures under title XX are limited to the amounts appropriated. In fiscal year 1980, the Congress appropriated $2.7 billion for title XX services. Title XX funds are allocated among States on the basis of their populations. The Federal Government reimburses States for 90 percent of their family planning costs and 75 percent of all other social services program costs up to their respective title XX ceilings. Federal and State expenditures for social services amounted to about $3.2 billion in fiscal year 1978. 2/ Of this amount, expenditures for homemaker/chore services were about $530 million (16 percent).

Within HHS, the Office of Human Development Services is responsible for administering the title XX program at the Federal level. HHS is responsible for

--evaluating State programs and

--providing technical assistance to States on the content of their service programs and on planning, reporting, administering, and evaluating their programs.

Title III

The 1978 amendments to the Older Americans Act of 1965 consolidated the existing titles III, V, and VII of the act, which respectively authorized social services, senior centers, and nutrition services into a revised and expanded title III, Grants for State and Community Programs on Aging (42 U.S.C. 3021). As revised, title III is designed to encourage and help State and local agencies concentrate resources on developing a comprehensive and coordinated service system to serve the Nation's elderly population (age 60 and over). Part B of title III mandates a broad

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1/Effective October 1, 1981, this program will be called "Title XX Block Grants to States for Social Services." It will function similar to the current title XX program except there will be fewer Federal requirements.

2/Latest year for which national expenditure data were available.

array of social services to the elderly, including home health and homemaker services.

Federal funds for the Part B social services program are provided on a formula grant basis to State agencies on aging. In fiscal year 1980, the Congress appropriated about $247 million for the title III social services program. In fiscal year 1980, the Federal Government reimbursed States for 75 percent of their cost of administering area agency plans and 90 percent of their social services expenditures. Beginning in fiscal year 1981, the Federal Government's share of the cost of providing social services was reduced to 85 percent.

HHS has overall responsibility for administering the title III social services program. Within HHS, the Commissioner, Administration on Aging, is responsible for administering the program. At the regional level, the Commissioner's responsibilities are carried out by the Office of Human Development Services' Office of Aging. States are required to carry out the program in accordance with their title III plan, which has been submitted to and approved by the Commissioner.

In fiscal year 1980, title III social services expenditures were about $276 million. Expenditures for home health type services--about $43 million--accounted for about 15 percent of this amount.

Appendix I compares the essential characteristics of the four programs discussed above.

OBJECTIVES, SCOPE, AND METHODOLOGY

In a May 16, 1980, letter, Senator Pete V. Domenici requested that we review the type of services provided under title III of the Older Americans Act and titles XVIII, XIX, and XX of the Social Security Act, with special emphasis on in-home health or health-related services for the elderly. Because all of the services are delivered in the home whether health related or not, we generally refer to the services in the remainder of this report as in-home services, unless we are referring to a specific program designation description of the service. We reviewed State practices in delivering in-home services to the elderly and on November 24, 1980, as requested by Senator Domenici, briefed his representative on the preliminary results of our work.

We reviewed the delivery of in-home services to the elderly in Colorado, Oklahoma, and the District of Columbia; we selected these locations because each used a different combination of the four programs to provide in-home services. Colorado primarily used Medicare and title XX, Oklahoma primarily used Medicaid, and the District of Columbia used all four programs. Within Colorado

and Oklahoma, we reviewed the activities of the county with the highest expenditures for in-home services, i.e., Denver and Oklahoma counties, respectively.

To review State policies and practices regarding the delivery of in-home services, we

--identified the provider organizations that delivered in-home services under each program being reviewed;

--judgmentally selected one or more providers from each program for review, depending on the significance of their expenditures; and

--reviewed a sample of cases selected at random from each provider to determine the basis for eligibility, type of services provided, cost of services provided, and compliance with program requirements.

The cases we reviewed under each program varied, depending on the program's significance as a source of funds for in-home services. We judgmentally limited our sample size to 30 for programs that represented a major source of funding for in-home services and to 10 for programs that did not.

We also obtained a needs assessment on the clients in our case samples. To do so, we asked the provider organization's staff member who was most knowledgeable about the client to complete a shortened version of a questionnaire developed, in collaboration with HHS, by a multidisciplinary team at the Duke University Center for the Study of Aging and Human Development. The complete questionnaire asked about an older person's status in five areas of functioning--social, economic, mental, physical, and activities of daily living. The shortened questionnaire addressed only two areas--physical and activities of daily living. We accepted the questionnaire responses at face value because staff and time constraints did not permit us to validate them by visiting the clients. However, we do not believe the above approach biased the needs assessments because the questionnaires were completed by the persons who were most knowledgeable about the client's condition, and because the shortened questionnaire adequately addressed an individual's functional limitations, which was the primary type of information we needed.

We interviewed HHS, State, fiscal intermediary, and provider program officials to obtain information regarding

--the operations of the various in-home service delivery systems,

--the impact of the various program requirements on the delivery of in-home services, and

--the administrative practices to assure program integrity.

We extensively reviewed prior reports--by GAO and other organizations--relevant to the delivery of in-home services to the elderly. 1/ Most of these reports dealt with individual programs or isolated issues concerning in-home care. Reviewing these reports helped us consolidate in this report available information on the elderly's needs and the existing programs' ability to meet those needs.

During a prior review 2/ of the administration of the title XX program in New York, we gathered data which were pertinent to this review. We used these data because they dealt with problems encountered in delivering in-home services to the elderly under existing programs.

During this review we also did limited work in Virginia to obtain an overview of that State's in-home delivery system. We selected Virginia because it had conducted an extensive study on the needs of its older citizens.

Very limited work was done in regard to utilization and cost controls because we performed an indepth review of these controls under the Medicare program--the major funding source for in-home services. The results of this review are included in our report entitled "Medicare Home Health Services: A Difficult Program To Control" (HRD-81-155, Sept. 25, 1981).

We did not attempt to select a statistically valid sample or to project our review results beyond the counties and States reviewed. Nor did we attempt to evaluate the quality of the in-home services provided. We focused our review on the problems associated with program design rather than program implementation.

1/Appendix II contains a summary of prior GAO reports.

2/"Federal and State Actions Needed To Overcome Problems in Administering the Title XX Program" (HRD-81-8, Oct. 29, 1980).

CHAPTER 2

LONG-TERM, IN-HOME CARE FOR THE ELDERLY: SERVICES AND NEEDS

Long-term, in-home care consists of services to the elderly who, because of chronic functional disabilities, need assistance with basic activities of daily living. The most common type of assistance needed by the elderly was homemaker/chore services, such as housecleaning or shopping assistance for those with heart problems. Many elderly also need assistance with personal care functions, such as bathing and dressing.

Our studies, although not projectable to the total elderly population, have indicated that between 10 and 22 percent of the elderly 65 years of age and older were not receiving all the homemaker/chore and personal care services they needed. Our studies also indicate that, for the elderly that have their needs met for homemaker/chore and personal care assistance, 76 percent of the cost of these services is provided by the family and friends.

LONG-TERM, IN-HOME CARE

Long-term, in-home care consists of services to persons who have lost some capacity for self-care due to a chronic condition. These services are categorized under the general headings of personal care and homemaker/chore services. As described below, they can be provided either formally, by individuals and agencies who are paid for their services or informally, by relatives and friends who provide assistance without pay.

Personal care services

Personal care services focus on the client's need for assistance with basic daily living activities. Home health aides provide assistance with bathing, oral hygiene, grooming, dressing, skin and foot care, feeding, and toileting (either with bedpan routines or helping clients to and from the bathroom). Aides also remind clients to take prescribed medications.

Homemaker/chore services

Homemaker/chore services focus on the client's home management needs. Homemaker services include performing routine light housecleaning, such as dusting, mopping, vacuuming, doing laundry, changing bed linens, washing dishes, and preparing meals. Chore services include running errands and shopping for groceries and medications. Persons who provide homemaker/chore services are usually the same individuals who provide personal care services to clients.

POTENTIAL UNMET NEED FOR HOMEMAKER/CHORE AND PERSONAL CARE SERVICES

The elderly who have some degree of functional disability need long-term, in-home assistance with basic daily living activities, and the services most often needed are of the homemaker/chore variety. The more seriously disabled elderly also require assistance with personal care activities.

Although not projectable to the total universe of the elderly, prior GAO studies have demonstrated that many elderly have an unmet need for homemaker/chore and personal care services. Our 1976 study of 1,311 elderly persons in Cleveland, Ohio, disclosed that about 16 percent of the sampled population had an unmet need for homemaker/chore or personal care services. Our 1978 study of 50 elderly persons in each of five locations disclosed the following:

Unmet Needs of the Elderly

Location	Percent of sampled population that did not get needed services: Homemaker/chore services	Personal care services
Allegheny County, Pennsylvania	16	22
Bernalillo County, New Mexico	22	12
Dade County, Florida	12	10
Hinds County, Mississippi	18	20
Pueblo County, Colorado	20	10

Although our studies and those done by others show that some amount of the functionally disabled elderly's long-term needs are not being met, they also show that families and friends provide a considerable amount of assistance. According to a Congressional Budget Office study, 1/ most functionally disabled persons receive long-term care from families and friends. In our Cleveland study, we found that the average annual cost of assisting an elderly person with daily living activities was about $2,400 per person. Family and friends provided services valued at about $1,820 or about 76 percent of the assistance needed.

1/Budget issue paper on "Long-Term Care for the Elderly and Disabled," February 1977.

Another study, financed by the Virginia Department of Welfare, also addressed the issue of family and friends as a source of long-term, in-home assistance to the elderly and concluded that a strong informal support network existed. This study, completed in 1980, examined the needs of and services available to 2,146 noninstitutionalized Virginians 60 years of age and older. The report on this study concluded the following regarding homemaker/chore and personal care services.

--Homemaker/chore services. During a 6-month period, about 18 percent of the elderly received help with routine household chores because they were unable to do them. In nearly 84 percent of the cases, the assistance was provided by informal sources, especially the spouse or another family member. Among those not receiving homemaker/household assistance, about 6 percent felt they needed it. About 71 percent of those who had not recently received homemaker/household assistance knew where they could obtain it. In most cases, they would seek help from their spouses or another family member.

--Personal care. According to the report, less than 8 percent of older Virginians had recently used personal care services. Among those receiving help with personal care, over three-fourths relied on relatives as their source of help. Since most of the caregivers were relatives, it was not unusual that much personal care was provided without payment. Only about 1 percent of the elderly not receiving help with personal care felt they needed it. Among the older people who had not used personal care services, almost three-fourths knew where to obtain it if needed. Almost 80 percent said they would get this help from their spouses or other family members.

The study concluded that

"* * * the strong informal support networks encompassing many old people in Virginia should be taken into account in program planning. Methods should be developed to promote, support and complement informal caregiving rather than to replace it. Clearly, any effort to design an effective system of services should give attention to the financial support, time and other resources which many family members and friends are willing to provide."

CONCLUSION

Studies to date have determined the needs of the elderly that relate to long-term, in-home care. These elderly basically require assistance with activities of daily living. Our studies, although not projectable to the total universe of elderly, have indicated that between 10 and 22 percent of the elderly 65 years of age and older were not receiving all the homemaker/chore and personal care assistance they needed. We also know that many of the elderly that receive assistance with activities of daily living are served by families and friends.

CHAPTER 3

WHAT PROGRAMS ARE AVAILABLE AND WHAT ARE THE IMPLICATIONS OF CHANGING PROGRAMS TO INCREASE THE AVAILABILITY OF LONG-TERM, IN-HOME CARE

Four Federal programs--Medicare, Medicaid, title XX, and title III--offer personal care and homemaker/chore services in the home, even though in-home services are not their primary mandate. Each program has restrictions which limit the availability of such long-term, in-home assistance. Funding ceilings, for example, restrict the number of elderly who can receive long-term, in-home services under titles XX and III. Eligibility requirements restrict services available under Medicare and Medicaid.

The objective of in-home services is to help elderly individuals whose needs can most appropriately be met by serving them in their homes. Cost and other factors, such as quality of life, should be considered in determining if long-term, in-home care is appropriate. There is a lack of consensus on whether providing long-term, in-home assistance significantly affects the number of elderly who are or will be receiving long-term care in nursing homes.

FOUR FEDERAL PROGRAMS AUTHORIZE PERSONAL CARE AND HOMEMAKER/CHORE SERVICES UNDER CERTAIN CONDITIONS

There is no Federal program specifically designed to provide long-term, in-home care for the elderly. However, four programs include personal care and homemaker/chore services among those authorized as primary or secondary services. The availability of these in-home services under each program is discussed below. Appendixes IV, V, VI, and VII provide detailed information on how the four States reviewed used these programs.

Medicare

Medicare provides home health services to clients who, due to illness, intermittently require the skilled services of a registered nurse. Having met the eligibility requirement for skilled nursing services, clients are also eligible to receive personal care services. Clients eligible for personal care services can receive homemaker services as incidental services.

Once a client's illness no longer justifies receipt of nursing services, all in-home services stop because the need for nursing services determines eligibility for all in-home services. In the

locations visited, Medicare predominantly provided skilled nursing services as opposed to unskilled personal care and homemaker services.

Medicaid

Medicaid is conceptually designed to provide both long-term and short-term, in-home services. Medicaid has two program components: home health and personal care. The home health component provides both skilled and unskilled care. Unlike Medicare, however, the client's need for skilled services is not a prerequisite for receipt of unskilled services. The personal care component provides only unskilled services. Both components limit the delivery of homemaker/chore services to persons who have a primary need for personal care services.

Medicaid home health services

The Medicaid home health services program provided relatively little in-home care in the States reviewed. Oklahoma, for example, seldom used the home health component. Colorado and Virginia did use the component, but it only provided 5 and 9 percent of their in-home services, respectively. In both States, this component funded less in-home service than either Medicare or title XX. HCFA national data showed similar funding patterns in most States.

While it was difficult to determine reasons, other than the restrictions on the delivery of homemaker/chore services, we identified several additional factors which may have restricted Medicaid home health use. First, Medicaid requires State matching funds, whereas Medicare is 100-percent federally funded. For example, Colorado pays about 47 percent of every Medicaid dollar spent, while the District of Columbia pays about 50 percent. Therefore, States tend to use Medicare whenever possible instead of Medicaid. This practice is encouraged by a Federal regulation which permits States to pay a premium and "buy in" to the Medicare insurance program for persons age 65 years and older. Therefore, as long as a client meets the Medicare in-home services eligibility requirement, Medicare is billed for the services provided.

A second factor which probably affects home health use is the so-called "spend down" process under Medicaid which tends to result in long-term care being provided in nursing homes. For example, certain elderly because of the amount of their resources are ineligible for Medicaid. If these persons use up their resources for medical bills they then become eligible. Many elderly become eligible for Medicaid only after incurring large medical bills--almost always as a result of some form of institutional care.

Still another factor which may restrict the use of Medicaid home health services is the reimbursement rate. Colorado, for example, placed low reimbursement rates on nursing and home health aide visits. This made the Medicaid program unattractive to some providers because they were reimbursed less under Medicaid than under Medicare for the same type of in-home service. One Colorado provider we visited received about $45 per nursing visit under Medicare, but only $28 under Medicaid. Likewise, the home health aide visits were capped at $4 under Medicaid, regardless of length of visit. Under Medicare, aide visits were reimbursed at $10.24 per hour for about a 2-hour visit. Provider officials stated that low reimbursement caps on the home health services acted as a disincentive to serve Medicaid clients.

Medicaid is the major public financier of long-term care services, but for the reason stated above, most of the long-term care is provided in nursing homes rather than in noninstitutional settings such as the home. The table below compares fiscal year 1978 Medicaid expenditures for intermediate care facilities and skilled nursing facilities (combined) to expenditures for home health services in the locations visited.

Comparison of Medicaid FY 1978 Expenditures for Long-Term Institutional Care to Home Health Services

	Program expenditures	
	ICF/SNF (note a)	Home health (note b)
Location	(thousands)	
Colorado	$ 94,226	$ 332
District of Columbia	15,394	1,263
Oklahoma	108,668	2
Virginia	123,419	942

a/Combined expenditures for both intermediate care facilities and skilled nursing facilities.

b/The home health amount excludes expenditures for the Medicaid personal care component. This primarily affects Oklahoma that had a large personal care program, but a relatively insignificant home health care program.

Medicaid personal care services

Few States have opted to implement the personal care component of Medicaid. HCFA reports indicate that about 16 locations have

implemented Medicaid's personal care component, but only New York and Oklahoma have made it a significant in-home program. However, Oklahoma's program is unique for two reasons. First, the program has been Oklahoma's primary source of funds for in-home services. Second, it has some unique program features:

--Care is available up to 7 days per week and from an average of 4 to 24 hours daily.

--The providers are individuals hired by the client.

--Pay to the providers is $10 plus the Federal Insurance Contributions Act tax per visit/day regardless of length of visit.

--The maximum monthly reimbursement to providers is capped at about $300.

Oklahoma's personal care program (commonly referred to as Nontechnical medical care) provides long-term care for many elderly. The average monthly caseload in 1980 was over 5,000 clients, and based on our sample, clients remained in the program an average of 31 months. The total cost to the State in fiscal year 1980 was about $20 million.

We did not attempt to determine specific reasons why Colorado or Virginia had not implemented Medicaid's personal care services component. We did, however, obtain a Colorado State official's opinion as to why it was not used. This official stated that the personal care component is delivered by individual vendors in the States that use it. In his opinion, this delivery method lacks control, monitoring, supervision, and quality of care. A second reason given was to contain costs. If the component was added, the State legislature would have to expand the Medicaid budget to cover the additional costs.

Title XX

The States we visited expended less than 13 percent of their total title XX funding allocation on homemaker/chore and personal care services. The other funds were for services for needy children, their families, and the disabled. According to an HCFA report, this funding trend was typical in most States.

A State, under title XX, can determine which services are to be provided. Thus, it would appear that this program could have constituted the basis for a major thrust in terms of long-term, in-home services. However, this has not occurred for two reasons:

--The title XX funding ceiling in many States has already been met or exceeded. Therefore, it is unlikely that States will be willing to develop new services under this title, as they would be responsible for meeting the total costs of all expenditures.

--Title XX support is central to children's services, for example, child daycare. Consequently, the elderly have to compete with other needy groups for a share of title XX moneys.

Colorado, the District of Columbia, and Virginia used title XX as one of their major in-home services funding sources. Officials from these locations stated that their title XX budgets for services to the elderly were not sufficient to meet all needs and that waiting lists existed for in-home services.

Title III

The wide range of services, combined with the limited Federal funding allocations, severely restricts the amount of title III funds available to provide personal care and homemaker/chore services to elderly persons with chronic functional impairments. Title III was authorized $247 million for fiscal year 1980, specifically for social services. The Administration on Aging requires that 50 percent of the State area agencies' allotments be expended for

--access services (transportation, outreach, and information and referral);

--in-home services (homemaker, chore maintenance, and visiting and telephone reassurance); and

--legal services.

Title III was not a significant funding source for in-home services in any of the four States reviewed. In Colorado, for example, about 8 percent of the title III funds was spent on in-home services. The list on the following page shows what services title III money provided in Colorado.

Service	Expenditure (thousands)
Meals	$ 3,021
Social services:	
Access	1,061
In-home	469
Legal	136
Community	641
Other	107
Area plan	213
State agency administration	467

In Colorado, Title III's primary social services objective was to serve the most needy elderly. To accomplish this, title III providers try to serve the low-income elderly, those elderly living where there are no other free or low-cost, in-home services available, the isolated elderly, and those elderly who might otherwise go into a care facility. Some program officials said that these service goals are difficult to implement or enforce because title III regulations do not allow providers to obtain proof of income information or to deny service to anyone age 60 or older. Because no elderly can be denied services, the chronically impaired elderly are not assured a higher service priority.

LITTLE IS KNOWN ABOUT THE COSTS AND BENEFITS OF INCREASING THE AVAILABILITY OF LONG-TERM, IN-HOME CARE

Our review of available data regarding the costs and benefits of increasing the availability of long-term, in-home services for the elderly indicated that there is a lack of information on both the costs and benefits. Little information was available on potential cost and although some studies have been made on the benefits of long-term, in-home care, the results of the studies were inconclusive.

Cost of providing long-term, in-home services to the elderly

Available data indicate that liberalizing existing programs to provide long-term, in-home services, or establishing a new program with less constraints on eligibility than now exist, could be costly because they would serve a greatly expanded universe of elderly. The expanded universe would result from serving the functionally disabled elderly who are ineligible under current programs to receive in-home services, but who would apply and would be eligible for these services under the new program. Until a reliable measure is available of this new target population's size, however, the

potential cost of a long-term, in-home assistance program cannot be accurately estimated.

Potential cost of expanding the Medicare program to provide long-term assistance services

The Medicare program contains costs by providing personal care services only to persons receiving skilled care. The Social Security Administration estimated the impact of removing the skilled care requirement from the Medicare program, thus permitting the program to serve the functionally disabled elderly. The Social Security Administration estimated that Medicare costs would have increased by about $1.25 billion in fiscal year 1978 because of the additional clients who would have become eligible to receive program services.

Example of the potential cost of expanding the Medicaid program to serve persons who only need homemaker/chore services

The Medicaid program contains costs by making the availability of homemaker/chore services contingent upon the client's need for personal care services. No estimates have been developed by HCFA of the added costs that would be incurred if Medicaid was expanded to cover the costs of homemaker/chore services only. However, our prior review in New York City demonstrated the potential cost impact of opening the Medicaid program to "homemaker/chore only" services in that city. New York City, in accordance with State Medicaid regulations, provided personal care services and homemaker/chore services 1/ under Medicaid's personal care provisions. The city attempted to contain costs by providing the lowest level of care necessary to allow elderly persons to remain in their homes. Thus, "housekeeping only" services were provided to persons who did not need personal care.

HHS auditors questioned New York City's use of Medicaid funds to provide "housekeeping only" services. Although the question has not yet been completely resolved, New York City and State officials asked HHS to consider the impact that prohibiting "housekeeping only" services under Medicaid would have on their ability to meet the needs of the elderly. The Mayor of New York City, in an April 20, 1979, letter to the Secretary, HHS, stated that such services were provided to 9,000 (36 percent) of the city's disabled and vulnerable aged clients. He said that termination of these services would cause an undue hardship to these clients. He also

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1/The city called these services "housekeeping services."

said the termination of these services could substantially increase Medicaid expenditures, in that many clients were eligible for a higher level of service, while the health of others would deteriorate without these services and they would then become eligible for the more expensive personal or nursing care. In summary, about 36 percent of the city's clients needed only homemaker services to continue to live independently, and this need would not be met unless HHS amended the regulations to allow the delivery of homemaker services to persons who do not require personal care. HHS auditors estimated that New York City's practice of serving such clients under the Medicaid program increased the Federal share of the city's Medicaid expenditures by about $15 million during January 1, 1977, to October 31, 1978.

Benefits of providing long-term, in-home services to the elderly

Although their data are inconclusive, four studies suggest that providing long-term, in-home assistance could result in significant benefits to the functionally disabled elderly:

--Prolonged life.

--Increased independence.

--Reduced institutionalization.

Results of these four studies are summarized below.

Homemaker services study

This study, entitled "Cost-Effectiveness of Homemaker Services for the Chronically Ill," 1/ involved 630 elderly persons. The experimental group (307 persons) received homemaker services for a year, while the control group (323 persons) received none. All persons involved in the study had been hospitalized for at least 3 days during the 2 weeks before the study period. The study showed the following:

1/Study funded under section 222 of the Social Security Act. The study was performed by William G. Weissert, Barabara B. Livieratos, and Julius Pellegrino of HHS, and Thomas T.H. Wan, Professor of Sociology, University of Maryland.

Observed characteristic	Study results: Experimental group	Study results: Control group
	(percent)	
Hospitalized (note a)	77	73
Placed in skilled nursing facility (note a)	16	18
Died	26	35

a/There was no significant difference in the average length of stay.

The study concluded that the only significant effect of providing homemaker services was prolonged life.

Stroke patients study

This study, entitled "Comparison of Care and Cost Outcomes for Stroke Patients With and Without Home Care," 1/ involved 50 stroke patients who were evenly divided into an experimental group which received in-home services and a control group which did not. The study found the following differences 9 months after the patients were released from the hospital.

Observed characteristic	Study results: Experimental group	Study results: Control group
	(number of persons)	
Still at home	22	8
In skilled nursing facility	1	8
Died	2	9
Total	25	25

The study indicated that providing in-home services was effective in both reducing institutional care and prolonging life.

1/Study reported on in the Administraion on Aging Program Development Handbook on Homemakers and Home Health Services for the Elderly.

Oklahoma study

In the spring of 1980, Oklahoma studied the in-home personal care program in one of its nine districts. The district's nurses evaluated 210 cases to determine the effects of the program. The approach was subjective since it was based on the opinions of the nurses involved. Nevertheless, the consensus of the nurses was that without the personal care program, about

--68 percent of the recipients would be immediately placed in skilled nursing facilities,

--17 percent of the recipients could remain in their homes but would need constant assistance by family or friends, and

--15 percent of the recipients could function independently with occasional supervision.

Urban Institute's Oklahoma study

Oklahoma's personal care program was also studied under a grant awarded by the Urban Institute, Washington, D.C. The report on this study, dated December 1980, recognized that Oklahoma's emphasis on in-home personal care, delivered by individual providers and financed by Medicaid, represented a unique approach to State delivery of in-home, long-term care services. The report stated that the growth of the program (from about $3 million in fiscal year 1971 to about $14 million in fiscal year 1979) reflected the State government's view that personal care, rather than skilled care, was the appropriate level of in-home services. The report pointed out that, although Oklahoma regards personal care as a service that can prevent or delay nursing home placement, nursing home populations in Oklahoma had grown alongside the personal care program and that in 1976 the nursing home bed to elderly population ratio in Oklahoma exceeded the national average. However, the report also stated that Oklahoma did not report the shortage of nursing home beds that existed in many States.

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Although studies of in-home services have not conclusively demonstrated the impact that such services have on nursing home placement, studies of nursing home patients have demonstrated that many persons in nursing homes do not need skilled care and could have avoided institutionalization if homemaker and personal care services had been available to them. HHS' Administration on Aging, in its program development handbook, states

"It is widely recognized that many elderly individuals currently placed in long-term care facilities do not require institutional care. Their placement reflects not medical need, but the absence of adequate supportive services in their communities. It has been variously estimated that between 15% and 47% of the elderly in long-term care facilities have been inappropriately institutionalized. Taking the former, conservative estimate, it follows that 15% of the $9 billion spent on nursing home care in the United States in 1975, or $1,350,000,000, was misallocated in terms of the type of care provided. The 1968 National Health Survey showed that 26% of older people in instituions received only personal care of the type that could well be delivered in the home, and an additional 12.7% received neither personal care nor professional nursing care."

However, in our review of 30 cases in Oklahoma county, Oklahoma indicated that the cost of in-home care may not differ significantly from nursing home care if extensive services are provided and all public assistance costs are considered. For instance, Oklahoma spent about $275 per month to maintain the elderly in their homes. This appeared to be significantly lower than the $630 per month required to maintain such persons in an intermediate care facility. However, the clients eligible for long-term, in-home care were also generally eligible for other types of assistance such as financial assistance under the Old Age Survivors and Disability Insurance or the SSI programs, or assistance under the Food Stamp program. When such clients enter an intermediate care facility, some of their public financial assistance is used to offset the cost of the intermediate care facility. The difference between the cost of long-term, in-home care and the cost of care in an intermediate care facility was not significant on the average, considering all public assistance costs. For our sample of 30 clients in Oklahoma's long-term, in-home care program, the cost of a client's care in an intermediate care facility would have averaged about $24 more per month.

Separate program for long-term care

The National Commission on Social Security, as required by section 361 of the Social Security Amendments of 1977, conducted a study of all aspects of the Social Security Administration and related programs and developed a policy blueprint for the kind of system that would best serve the Nation in the future. The March 1981 National Commission's report, as it related to long-term care stated that

"* * * noninstitutional alternatives to long-term care should be encouraged. Today, approximately 5 percent of those over 65 live in institutions. About 85 percent of the residents of nursing homes are over 65; 75 percent of these are over the age of 75. Not only will the proportion of the aged rise in relation to the rest of the population in the future but also a greater number of them will be living to older ages. Thus, the need for nursing home or similar institutional care will increase in the coming years. Many placements in institutions might be unncessary, however, if alternative care were available.

"Medicare and Medicaid emphasize institutional care rather than alternatives. For example, Medicaid now pays $10 billion per year, about 40 percent of its total budget, to nursing homes. This sum goes to support only 10 percent of the program's beneficiaries.

"Providing quality long-term care presents a combination of social, medical, and financial challenges. As presently constituted, Medicare and Medicaid alone cannot meet them satisfactorily. The Commission recommends that a separate title of the Social Security Act be created to provide services other than acute medical and hospital care to needy persons who require long-term care. This program would be operated by the States and financed with both Federal and State funds, much as Medicaid is today.

"A broad range of services should be available to provide quality care in a way which will strengthen community-based and in-home services and reduce the need for long-term institutional care. Program benefits might include nursing home services; rehabilitation services; residential or boarding home care; home health, homemaker, and other in-home services; adult day care; and aid with minor home remodeling to adapt to handicaps. A State agency would be required to assess the need for long-term care in each case, establish criteria for what care is most appropriate, encourage the development and coordination of services and reimburse providers of care.

"Paying for these services under a separate title would identify the range of needed long-term care services and their costs with greater precision and public concern than now exists. It would also create a better

basis for future decisions with respect to local needs for services, whether different income and resource requirements should be established for long-term care than for acute care, and whether other changes in long-term care provisions will be needed to meet changing future needs."

The voluntary sector as a provider of services to the elderly

The Subcommittee on Human Services of the House Select Committee on Aging stated in a report, entitled "Future Direction for Aging Policy: A Human Service Model," May 1980, that the voluntary sector is known to provide about $80 to $100 billion worth of services. The elderly received about 6 to 10 percent of such services. The voluntary sector, according to this report, is one of the greatest repositories of knowledge and experience about human needs and the largest human resource pool. The report stated that one of the most complete examinations of volunteer activity was undertaken in 1973 by ACTION in conjunction with the Census Bureau. The study concluded that 37 million Americans contributed an average of 9 hours a week to volunteer services. This was equivalent to 3.5 million full-time workers each year. Over 29 percent of all volunteers primarily worked with the elderly. The percentage of workers dealing with the elderly was highest in the area of health agencies (41 percent) and social welfare agencies (51 percent). The report concluded that volunteeer participation in human services was essential and there must be an increased recognition of its value for and by the elderly.

CONCLUSIONS

There is no Federal program specifically mandated to provide long-term, in-home services for the elderly. Medicare, Medicaid, title XX, and title III offer personal care and homemaker/chore services in the home, even though in-home services are not their primary mandate. However, each program has restrictions which limit the availability of such long-term, in-home assistance. Removing these restrictions would make in-home services available to more elderly persons which, in turn, would increase the cost of these programs.

Various studies generally agree that in-home services prolong life and maintain or increase the elderly's independence. They disagree, however, on whether providing long-term, in-home assistance has any impact on the number of elderly who are or would be receiving long-term care in nursing homes.

In its March 1981 report, the National Commission on Social Security (see p. 22) recommends that a separate title of the Social Security Act be created to provide services other than acute medical and hospital care to needy persons who require long-term care.

In our opinion, to have a better foundation for policy decisions, more information is needed on

--the extent of the existing network of service providers (Federal, State, and local programs, family and friends, and the voluntary sector) that are serving the elderly and why about 10 to 22 percent of the elderly are not receiving all the services they need from this network (see ch. 2); and

--the cost of providing long-term, in-home services to the elderly and what effects the Federal subsidy of such services would have on the existing network that is serving the elderly.

We believe that more information on the costs and benefits of serving the elderly in the long-term, in-home setting would be helpful in making policy decisions. In our opinion, the most significant issue facing officials concerned with meeting the long-term, in-home needs of the elderly is how to contain cost without unreasonably restricting the availability of needed services.

Although we did not obtain agency comments, we did meet with HHS officials working in the long-term care for the elderly area, who agreed with our conclusions that an improved knowledge base would be helpful in making policy decisions concerning in-home care for the elderly.

COMPARISON OF ESSENTIAL CHARACTERISTICS OF FOUR PROGRAMS FUNDING IN-HOME SERVICES

	Social Security Act			Older Americans Act
	Title XVIII	Title XIX	Title XX	Title III
Services authorized:				
Nursing	yes	yes	no	yes
Therapy	yes	yes	no	yes
Home health aide	yes	yes	yes	yes
Homemaker	no	no	yes	yes
Chore	no	no	yes	yes
Medical supplies and appliances	yes	yes	no	no
Program eligibility requirements:				
Client must meet age requirement	yes	no	no	yes
Client must meet income requirement	no	yes	yes	no
Client must need part-time or intermittent skilled nursing care	yes	no	no	no
Client must be homebound	yes	no	no	no
Services to client must be authorized by a physician in accordance with a plan of care	yes	yes	no	no
Services must be included in State Plan	(a)	yes	yes	yes
Administration	Federal	State	State	State
Funding	open ended	open ended	capped	capped

a/ Federally administered program--no State Plan required.

APPENDIX II

SUMMARY OF GAO REPORTS ISSUED ON MATTERS RELATED TO IN-HOME SERVICES

Report title	Date of issue
The Well-Being Of Older People In Cleveland, Ohio (HRD-77-70)	Apr. 19, 1977
Home Health--The Need For A National Policy To Better Provide For The Elderly (HRD-78-19)	Dec. 30, 1977
State Programs For Delivering Title XX Social Services To Supplemental Security Income Beneficiaries Can Be Improved (HRD-79-59)	Apr. 11, 1979
Home Health Care Services--Tighter Fiscal Controls Needed (HRD-79-17)	May 15, 1979
Conditions Of Older People: National Information System Needed (HRD-79-95)	Sept. 20, 1979
Conditions And Needs Of People 75 Years Old And Older (HRD-80-70)	Oct. 15, 1979
Entering A Nursing Home--Costly Implications For Medicaid And The Elderly (HRD-80-12)	Nov. 26, 1979
Evaluation Of The Health Care Financing Administration's Proposed Home Health Care Reimbursement Limits 1/ (HRD-80-84)(HRD-80-85)	May 8, 1980
Comparison of Data on Older People in Three Rural and Urban Locations 2/ (HRD-80-83)	May 23, 1980.

1/Letter report to the Honorable Bob Packwood and the Honorable Sam M. Gibbons.

2/Letter report to Chairman, Federal Council on Aging.

STUDIES OF THE ELDERLY POPULATION

THE CLEVELAND STUDY

This GAO study involved a statistical sample from over 80,000 people in Cleveland, Ohio, who were 65 years old or older and were not in institutions such as nursing homes. In the study, 1,609 older persons were interviewed in 1975, and 1,311 were reinterviewed a year later. The interviewers used a questionnaire developed by Duke University in collaboration with HHS. The questionnaire asked about an older person's status in five areas of functioning--social, economic, mental, physical, and activities of daily living. For this report, we used the data on activities of daily living for the 1,311 older persons interviewed in 1976.

THE OREGON STUDY

The Lane County, Oregon, study was conducted by the University of Oregon and the Lane County Community Health and Social Services Department. The Oregon study was initiated to develop a comprehensive data base for planning programs for persons 60 years old and older living in the county.

The selection process for the Oregon study involved a statistical sample of 1,197 people from six subareas of the county. The people sampled were interviewed in 1978. Data from the study were to be used for planning purposes.

We segregated data on 868 persons 65 years old and older from the Lane County sample and used the data in this report.

THE SSI STUDY

This GAO study involved 250 recipients of financial assistance under the SSI program. We interviewed 50 SSI recipients selected at random from the SSI population in each of five counties: Allegheny County, Pennsylvania; Bernalillo County, New Mexico; Pueblo County, Colorado; Dade County, Florida; and Hinds County, Mississippi.

We conducted interviews in 1978 using the questionnaire developed by Duke University. We modified the questionnaire by replacing questions on employment and training with questions on nutrition, escort, and home repair services. For this report, we used the data on activities of daily living for the 250 persons interviewed.

THE KENTUCKY STUDY

The Gateway Health District studied the demographic characteristics and needs of people 60 years old and older living in the district. This district consists of five counties in northeastern

APPENDIX III

Kentucky (Bath, Menifee, Montgomery, Morgan, and Rowan) within the Cumberland Plateau.

A statistical sample of people 60 years old and older living in the five-county area was selected for interview. This sample included people from rural and urban areas and people in institutions. People not in institutions were interviewed in 1977. From the sample we segregated and analyzed data on 128 people 65 years old and older, not in institutions, and living in either an unincorporated area or an incorporated area of fewer than 2,500 people. We refer to the data provided on these 128 people as the Kentucky study.

DELIVERY OF IN-HOME SERVICES--COLORADO

Title XX was Colorado's largest funding source for in-home services to the elderly, although Medicare expenditures were also significant. The latest available annual expenditures for the four programs' in-home services follow:

Program	Fiscal year (note a)	Expenditures (thousands)
Medicare	1978	$ 4,200
Medicaid-- home health	1978	660
Title XX	1980	6,870
Title III	1980	470

a/Fiscal year 1980 data were not available for two programs. For purposes of showing Colorado's relative use of these four in-home programs, we used the latest expenditure data available on each one. (Medicare is an estimated expenditure.)

Title XX and Medicare, the largest Colorado programs, are described below for comparison and contrast to the other three locations we reviewed.

Title XX--Adult homemaker program

In all but one Colorado county, adult homemaker services were provided directly, rather than purchased, by county employees (homemakers/home health aides). Most aged persons, to be eligible, are either SSI recipients; eligible for and receiving Medicaid benefits; receiving financial assistance from either Colorado's Aid to the Needy Disabled, Aid to the Blind, or Old Age Pension programs; or, regardless of income level, are unable to protect their own interests and are threatened by abuse, neglect, or exploitation.

Homemaker services were defined as those to assist eligible adults in their own homes to overcome specific barriers in maintaining, strengthening, and safeguarding their functioning. The following list is a description of the specific tasks provided by a homemaker. The first set were considered primary services, such as when a recipient needed these services as a prerequisite to receive the personal care services. The homemaker tasks were

--assisting with home management by vacuuming, dusting, cleaning, linen changing, ironing, mending, grocery shopping, and preparing meals;

--providing personal care services by assisting with bathing, grooming, dressing, and exercising, under a registered nurse's supervision;

--providing educational and supportive services; and

--providing transportation for shopping and medical needs when other resources were not available.

We visited Denver County as it expended the most money for homemaker services. To determine how often homemaker chore and personal care services were being delivered, a random sample of 30 clients receiving services in October 1980 was drawn from Denver County's caseload. The clients' case files were reviewed and the results are summarized below.

Sample Results of Services to 30 Clients During October 1980

Average hours of service received by clients	12
Wage range per hour for homemakers	$4.15 to $5.04
Average monthly cost per case in sample, including county overhead and employee fringe benefits (note a)	$116
Average number of years client is in program	4

Services Most Frequently Provided and Number of Clients Receiving Them

Homemaker/chore services	
Housekeeping (e.g., vacuuming, dusting)	29
Laundering, changing linens, mending	24
Grocery shopping, errands	11
Food preparation	7
Personal care services (note b)	
Grooming (e.g., combing hair)	10
Bathing	7

a/Average monthly cost per case for the entire caseload over 1 year ranged from $116 to $129.

b/Personal care services must be authorized and supervised by a nurse, and are also incidental to homemaker/chore services.

Some Denver County officials said they had a waiting list of persons needing title XX homemaker services. Even though there were only 12 names on the waiting list as of October 1980, more names could be added, according to officials. However, the service and intake workers have stopped referring clients to the program because they are aware that it is at caseload capacity. Because caseload limit has been reached, emergency cases are given one-time assistance. Frequently, this entails delivering groceries to an elderly person's home.

Client eligibility and reimbursement processes

Title XX homemaker services are determined necessary by county level employees, including the social services' service workers. A client's eligibility, for example, is determined by reviewing either SSI or Old Age Pension computer listings. (For clients who need protection, income is not a criterion.) Once it is verified that a client is eligible, the service worker, homemaker supervisor, registered nurse, etc., develop the plan of care. These are reassessed every 6 months and modified as necessary.

Because the title XX services are generally provided directly by county staff rather than purchased from private sources, State officials said reimbursement and service controls were not problems. The State reimburses counties for 80 percent of the salaries, fringes, and overhead costs. Each county has to match the State and Federal funds with 20 percent local money.

Medicare--title XVIII

Medicare services are mostly provided by about 45 certified home health agencies throughout Colorado. In the rural areas, the County Health and Social Services Departments provide the Medicare services.

In Denver County, two certified providers primarily employed or contracted for registered nurses to deliver the home-health services to eligible clients. We visited these two providers and reviewed a sample of 60 cases. A combined summary of the level of services delivered by these providers to 60 Medicare clients follows.

Services Most Frequently Provided

	Number of clients
Nursing services:	
Vital signs (note a)	59
Blood pressure checks (note a)	52
Instruction on medication	46
Instruction on diet	37
Average number of nurse visits per month	4
Aide services:	
Bathing assistance	50
Skin care	46
Grooming	41
Laundering	38
Light housecleaning	34
Average number of aide visits per month	7

Average Length of Time Client Had Received Services

	Months
Part A--30 clients (Medicare clients that must be hospitalized before receiving services)	4
Part B--28 clients (Medicare clients that do not need to be hospitalized before receiving services)	8

a/Nurses usually provide another service as the primary reason for their visit.

One provider charged $44.50 per nurse visit and $10.24 per hour for aide visits. The other charged $38.00 per nurse visit and $12.00 per hour for aide visits. One provider had no aides on its staff, so all aide services were subcontracted from either the title III subgrantee or one private homemaker agency. The other provider had only a few aides on its staff.

Medicare utilization and reimbursement controls

The responsibility for assuring that Medicare recipients are being provided appropriate home health care has been delegated by HCFA to the Colorado Department of Health and the fiscal intermediary. In addition, Medicare regulations require providers to conduct

--periodic reviews of the client's plan of treatment at least once every 60 days to determine the adequacy and appropriateness of care;

--evaluations of overall policy and administrative practices to assess the extent to which the agency's program promotes patient care that is appropriate, adequate, effective and efficient; and

--a quarterly review of clinical records to assure that established policies are followed in providing services.

HCFA has no specific national guidelines on review standards for service reimbursement claims. Instead, HCFA has each fiscal intermediary establish its own screening criteria. The Colorado fiscal intermediary utilized:

--A clerical guide to screen for claims that exceed established limits for the number of skilled nursing home visits a patient can receive per diagnosed condition. There are no claim denials at this clerical level; however, claims exceeding the limits are forwarded to the medical review unit.

--A reviewing nurse in the medical review unit to determine the medical necessity for continuing home health care beyond the predetermined limits.

HCFA reviews the fiscal intermediary to assure itself that the reimbursement process is being properly implemented.

The fiscal intermediary also conducts an annual review to determine the allowable costs of each provider. This procedure results in the amount that the provider is allowed to charge per nurse and aide visit, and in a final cost settlement.

DELIVERY OF IN-HOME SERVICES--

THE DISTRICT OF COLUMBIA

Title XX and Medicaid were the District of Columbia's largest funding sources for in-home services to the elderly. The latest available annual expenditures for the four programs' in-home services follow:

Program	Fiscal year (note a)	Expenditures (thousands)
Medicare	1978	$1,570
Medicaid:		
Home health	1979	1,230
Personal care	1979	1,110
Title XX	1980	2,900
Title III	1980	340

a/Fiscal year 1980 data were not available for two programs. For purposes of showing the District's relative use of these in-home programs, we used the latest available expenditure data.

Only the two largest programs are described in the following sections to compare and contrast the District with the three other locations included in this review.

Title XX--homemaker and chore services

The Department of Human Services (DHS), Social Services Division, manages title XX homemaker and chore services. The eligibility requirements for both programs are the same. Clients must be

--recipients of SSI payments;

--those whose income does not exceed 65 percent of the District's median income; or

--those in need of protection, without regard to income.

Homemaker services are provided to convalescent, disabled, or aged adults who need assistance with basic homemaking, household and personal affairs management, and personal care. Personal care can only be provided as an incidental service--that is, when the need for personal care is secondary to the need for homemaking services, when personal care is necessary to support the continued medical treatment plan, or when the individual is ineligible for both Medicare and Medicaid home health services.

DHS contracts with two private homemaker service agencies to provide title XX homemaker services. Because clients receiving this service may be severely impaired or senile, DHS requires that the contractors' social workers and homemaker supervisors adequately supervise their homemakers who deliver services. DHS paid $5.24 to $5.65 per hour for the contracted homemaker services.

Chore services, which include performing household tasks, essential shopping, and other light work, are provided to enable elderly individuals to remain in their homes. These persons, although unable to perform the household tasks, must be able to care for their personal needs, make their own decisions, and supervise the chore provider.

Elderly adults who become chore service clients select and hire their chore providers. These providers deliver the chore services and are paid for the number of hours it takes to perform tasks the clients need. DHS reimbursed the individual providers $2.90 per hour.

We reviewed a sample of 30 title XX elderly client case files, 10 each from the two private homemaker agencies and 10 from the individual chore providers. Selected data developed during the review follow.

Homemaker and Chore Programs
Comparison of Services for
1 Month to 30 Elderly Clients

Description	Homemaker program		Chore program
	Provider A	Provider B	
Average age of clients	81	74	75
Average number of service hours	57	73	55
Average number of visits	15	17	16
Average monthly cost per case	$301	$414	$158
Provider hourly charge to DHS	$5.24	$5.65	$2.90
Average number of years in program	2	2	4

In fiscal year 1980, the District provided $30,230,900 over the amount required to earn its title XX allotment. However, since most title XX funds were used for children's programs, the DHS homemaker and chore intake office closed from May to September 1980 due to lack of funds. Consequently, these two programs were unable to accept any new elderly clients.

Medicaid--home health and personal care programs

The District's Department of Human Services, Medicaid Home Health Care Division, administers both Medicaid home health and personal care services. Home health services are provided by the District's Home Health Care Division staff and three contract agencies. In 1980, personal care services were rendered by 488 individual providers.

To be eligible for home health services, a client must have a need for nursing services in the home. A nursing visit costs between $23.75 and $27.63, depending on provider. Aides who provided personal care and homemaker/chore services cost $8.61 to $10.50 per hour. In a sample of 15 clients receiving home health services for 1 month from one contractor, the clients received an average of 19 hours of aide service at $8.61 per hour and 2 nurse visits at $27.63 per visit for a total monthly average cost of $219.

To be eligible for personal care, clients must be eligible for medical assistance and must be homebound but not bedridden. Ordinarily, the client is unable to leave home except for medical treatment. The client receiving personal care services may also receive homemaker services. Individual providers are paid $2.90 per hour and typically work with a client 4 hours per day, 5 days per week. The providers are supervised by a public health nurse. Total monthly cost averaged $255 on 11 clients sampled.

DELIVERY OF IN-HOME SERVICES--OKLAHOMA

The Medicaid personal care program was Oklahoma's largest funding source for in-home services to the elderly. The latest available annual expenditures for four programs which provide in-home services follow.

Program	Fiscal year (note a)	Expenditures (thousands)
Medicare	1978	$ 1,750
Medicaid	1980	19,800
Title XX	1980	470
Title III	1979	300

a/ Fiscal year 1980 data were not available for Medicare and title III. For purposes of showing Oklahoma's relative use of these four in-home programs, we used the latest available data on these programs. The Medicare amount is an estimate.

The Medicaid personal care program is described below to compare and contrast Oklahoma with the three other locations included in this review.

Medicaid--personal care

The Oklahoma Department of Human Services administers the Medicaid personal care program, commonly referred to as the Non-technical medical care (NTMC) program. This program was implemented in 1970. County human services departments in Oklahoma determine client financial eligibility and assess social services needs. The State recruits, trains, and pays individual providers, even though they are considered employees of the client.

Eligibility criteria for the NTMC program includes both financial and medical requirements. Financial eligibility specifically considers income and capital resources. Medical eligibility specifically requires one of three conditions: (1) that the client have a present medical condition or health problem that, when combined with the individual's current inability to perform daily self-care activities, indicates the potential placement of such individual into a nursing home unless in-home services are provided; or (2) that the client is bedfast or chairfast; or (3) that the client requires assistance of another person to walk.

The individual providers are considered employees of the client. These persons are nonprofessionals who provide physician-ordered personal care and homemaker services on an average of 4 hours per day and up to 7 days per week. The providers were paid a daily rate of $10.00.

The NTMC program is set up to primarily serve the personal care needs of clients but includes homemaker/chore services as necessary. Program officials stated that homemaker/chore services are provided because persons who cannot take care of their personal needs due to physical limitations cannot maintain a safe and clean living environment either. Services provided to 30 NTMC clients sampled are shown below.

Service/tasks	Number of clients
Medical (note a)	
Oral medication	26
Vital signs	8
Diet instruction	16
Medication instruction	16
Other	4
Personal	
Feeding	14
Dressing	25
Grooming	27
Walking	29
In/out bed/chair	10
Bathing	29
Toileting	10
Foot care	27
Skin care	29
Other	5
Homemaker/chore	
Shopping/errands	20
Preparing meals	28
Housekeeping	30
Laundry/linens	30

a/The nonprofessional provider delivered these services in accordance with an approved care plan.

An average of 23 days of service was provided to these 30 clients. The clients had been receiving services in this program an average of 31 months.

Monitoring the NTMC program

NTMC nurses monitor the performance of providers through visits to the clients' homes. These visits are to be made at least once every 60 days. The nurses told us they can tell how the provider

is doing by looking around the home and talking to the clients during home visits. The nurses said if they have suspicions concerning providers, they refer the names to the DHS Inspector General for investigation. The NTMC nurses make frequent visits to new providers for the first few months until they feel confident that the providers can take care of the clients. Providers are instructed to call the NTMC nurse when a need arises, and the nurse will make a visit. Officials said some nurse visits are made to try and resolve problems between providers and clients. If the problem cannot be resolved, the nurse helps the client find a new provider.

DELIVERY OF IN-HOME SERVICES--VIRGINIA

Title XX was Virginia's largest funding source for in-home services to the elderly. The latest available annual expenditures for the four programs' in-home services follow.

Program	Fiscal year (note a)	Expenditures (thousands)
Medicare	1979	$ 3,650
Medicaid-- home health	1980	1,500
Title XX	1979	10,520
Title III	1980	380

a/Fiscal year 1980 data were not available for Medicare and title XX. For purposes of showing Virginia's relative use of these four in-home programs, we used the latest available data on these programs.

The title XX and Medicare in-home programs are described in the following sections.

Title XX's chore, companion, and homemaker services

The Virginia Department of Welfare and the Department for the Visually Handicapped administer title XX in-home services. Most elderly persons are eligible for chore, companion, and homemaker services if they are SSI recipients, Old Age Assistance recipients, low income, in need of protection, or permanently and totally disabled. The following list is a description of in-home services we reviewed which Virginia provided to its elderly:

--Chore: Performance of household and home maintenance tasks, such as heavy housecleaning, floor and yard maintenance, painting, and snow removal for an eligible adult who, because of advanced age, blindness, disability or infirmity, is unable to perform these tasks and no one else is reliable to provide them without cost (e.g., family or friends).

--Companion: Provision of light housekeeping, personal aid, and companionship services to an eligible adult who, because of advanced age, blindness, disability or infirmity, is unable to perform these tasks and there is no one available to provide these services without cost.

--Homemaker: Performance of activities, such as personal care, household maintenance, nutrition, and hygiene, by a

person trained in homemaking skills who is an employee of an organized, approved homemaker agency.

Some service objectives are to

(a) enable clients to improve their living standards,

(b) provide safety and security for clients in their own living situation,

(c) maintain independent home living arrangements of clients whose age or disability has diminished capacity, and

(d) supplement clients who are unable to assume total responsibility for household and/or personal care tasks.

For the fiscal year ended in 1979, expenditures for these three services were 13 percent of the total $64 million Federal allotment and the $19 million non-Federal funding sources. Adoption, child daycare, employment, family planning, and protective services for children consumed a significant portion of the State's title XX funds.

The companion program served the most adults and also cost the most. Of the $10.5 million expended for the three in-home services in fiscal year 1979, $9.8 million went to the companion services category alone. Companion services are purchased.

Virginia program officials said that a barrier in providing sufficient in-home services is the Federal title XX funding ceiling, coupled with the fact that the ceiling does not increase annually to offset inflation. Already, some social services departments have had to reduce the number of hours they will approve for current clients. Besides these cutbacks, officials stated they have indications of unmet needs for in-home services (elderly persons who need these services now but are not getting them) because resources are not available. In one official's opinion, the funding problems will continue to restrict the ability to cover future demands, because the number of persons who will need in-home services will increase and many of them will not be able to pay for the assistance themselves. No title XX case files were reviewed in Virginia.

Medicare

Medicare in-home services were delivered by the Virginia State Health Department through its 134 local health departments and some independent home health agencies. The per visit charges to Medicare by one County Health Department were $35 per nurse visit and $20 per aide visit, while one independent provider charged $40 per nurse

visit and $15 per hour for an aide visit. No case samples were reviewed for Virginia Medicare clients. However, we obtained the following comments from officials regarding Medicare regulations.

Medicare providers said that no client was ever refused service even if the Medicare skilled care requirement was not met. In such cases, the Virginia Department of Health wrote the costs off as bad debts instead of letting a needy person go unserved. One independent provider charged the cost against alternate funding sources such as the United Way.

Medicare utilization controls

The Virginia State Health Department sends its Medicare claims to HCFA's Office of Direct Reimbursement. Prior to claim submission, the State Health Department performs a review to verify that

--the actual number of visits has not exceeded authorized visits,

--the treatment given was needed and allowable, and

--the forms were complete.

Then the HCFA computer screens the claims for the number of visits versus diagnosis. If the claim exceeds the parameters, the computer rejects it and it is reviewed manually. HCFA does not, however, routinely audit home health agencies because of the low-dollar expenditures for in-house services compared to high-dollar expenditures for hospitals.

Some of the private home health agencies use private fiscal intermediaries for processing the home health claims. One fiscal intermediary relies on desk audits for the purpose of detecting errors on claims and to ensure that claims do not exceed home visit limits.

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